Washington State Department of Social & Health Services

MAA Medical Assistance Administration

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Washington Medicaid Integration Partnership

Exemption/Disenrollment Request

[X] **I am happy with the way I receive my health care now and do not want to be in the Washington Medicaid Integration Partnership (WMIP) Project.**

My name is: _____

My PIC, Case, or Assistance Unit Number: _____

My Date of Birth: _____

My Social Security Number: _____

☐ Please check here if you are currently enrolled in Molina Integration (look for the letters "MINT" on your Medical ID Card) and you have had **NO** services (doctor visits, emergency room, etc.) this month.

☐ Please check here if you are currently enrolled in Molina Integration ("MINT" on your Medical ID Card) and you have had **SOME** services (doctor visits, emergency room, etc.) this month.

Your signature: _____

Date: _____

Refold the form with the business reply address on the outside and send it to us. (No postage is needed).

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